Consolidated Benefits (CoBen)

General Information

Eligibility: BU 2, 7, 8, 16, 17, 18, 19, and Excluded Employees

Benefit Allowance	Cash Option
Combined employer contribution for health, dental and vision	In lieu of option for employees with other qualifying health and/or dental coverage

Delta Dental: 24-Month Restriction

- Employees in CoBen do not serve the State Dental Program's Delta Dental 24-month restriction period
- Newly hired employees and those who transfer from a Bargaining Unit that is not eligible for CoBen to one that is eligible, including those who are currently serving the 24-month restriction, will be allowed to enroll or change to a Delta Dental plan

Ways to Calculate Costs

Benefits Calculator (preferred)

- Automatically calculates amounts added/ deducted based on election choices
- Basic vision plan is automatically added into the calculation

Benefits Worksheets

- Available in the CoBen handbook
- Employees manually calculate costs

Appeals Process

- CalHR will review appeals submitted by personnel offices on a case by case basis in the event of an administrative error

Email
CoBen@calhr.ca.gov

Fax
(855) 629-7814

Cash Option Programs (CoBen & FlexElect)

Learning Objectives

- Tell the difference between FlexElect and CoBen Cash Options
- Determine eligibility
- Understand qualifying coverage
- Know the differences that apply to Permanent-Intermittent (PI)

Available Cash Option Programs

FlexElect	CoBen
• Bargaining Units 1, 3, 4, 5, 6, 9, 10, 11, 12, 13, 14, 15, 20 and 21	• Bargaining Units 2, 7, 8, 16, 17, 18, 19, and Excluded Employees

- Once enrolled, employees do not need to re-enroll each year
  - Exception: PI employees must reenroll each year

Eligibility Criteria

State employees designated:

- Rank and File
- Managerial
- Supervisory
- Confidential
- All other employees excluded from collective bargaining

Additional Requirements:

- Permanent status
- Limited-term or TAU
  - FlexElect: Mandatory right of return to a permanent position
  - CoBen: Mandatory right of return not required
- Work one-half time or more
- Permanent intermittent

Qualifying Coverage

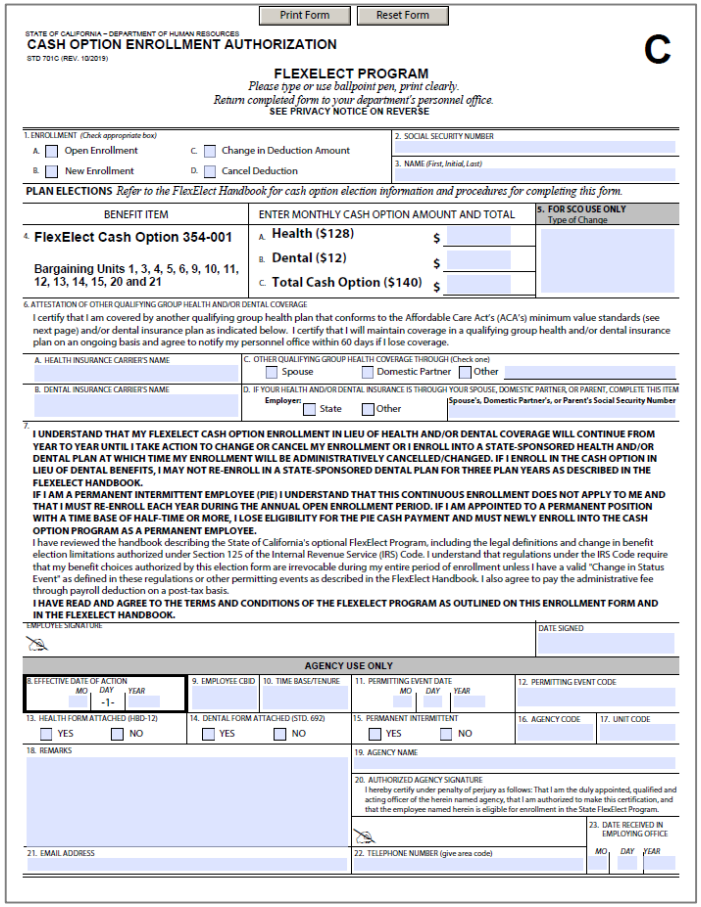
- Employee must have qualifying group coverage to be eligible for cash in lieu of health or health and dental
  - Health coverage including but not limited to the following are not qualifying coverage to receive the Cash Options:
    - TRICARE, Medicare, Medi-Cal, Covered California, VA, Indian Reservations

Cash Option Monthly Amounts

Coverage	FlexElect	CoBen
Health Only	$128	$130
Dental Only	$12	Not available
Health and Dental	$140	$155
Administrative Fee	$1	$0

- Unit 6 employees may not receive the FlexElect Cash Option in lieu of their dental insurance

Cash Option Enrollment Forms



Print Form Reset Form

STATE OF CALIFORNIA – DEPARTMENT OF HUMAN RESOURCES
CASH OPTION ENROLLMENT AUTHORIZATION
STD 701C (REV. 10/2019)

C

FLEXELECT PROGRAM
Please type or use ballpoint pen, print clearly.
Return completed form to your department's personnel office.
SEE PRIVACY NOTICE ON REVERSE

1. ENROLLMENT *(Check appropriate box)*
A. ☐ Open Enrollment C. ☐ Change in Deduction Amount
B. ☐ New Enrollment D. ☐ Cancel Deduction

2. SOCIAL SECURITY NUMBER
3. NAME *(First, Initial, Last)*

PLAN ELECTIONS *Refer to the FlexElect Handbook for cash option election information and procedures for completing this form.*

BENEFIT ITEM	ENTER MONTHLY CASH OPTION AMOUNT AND TOTAL	5. FOR SCO USE ONLY Type of Change
4. FlexElect Cash Option 354-001 Bargaining Units 1, 3, 4, 5, 6, 9, 10, 11, 12, 13, 14, 15, 20 and 21	A. Health ($128) $ B. Dental ($12) $ C. Total Cash Option ($140) $	

6. ATTESTATION OF OTHER QUALIFYING GROUP HEALTH AND/OR DENTAL COVERAGE
I certify that I am covered by another qualifying group health plan that conforms to the Affordable Care Act's (ACA's) minimum value standards (see next page) and/or dental insurance plan as indicated below. I certify that I will maintain coverage in a qualifying group health and/or dental insurance plan on an ongoing basis and agree to notify my personnel office within 60 days if I lose coverage.

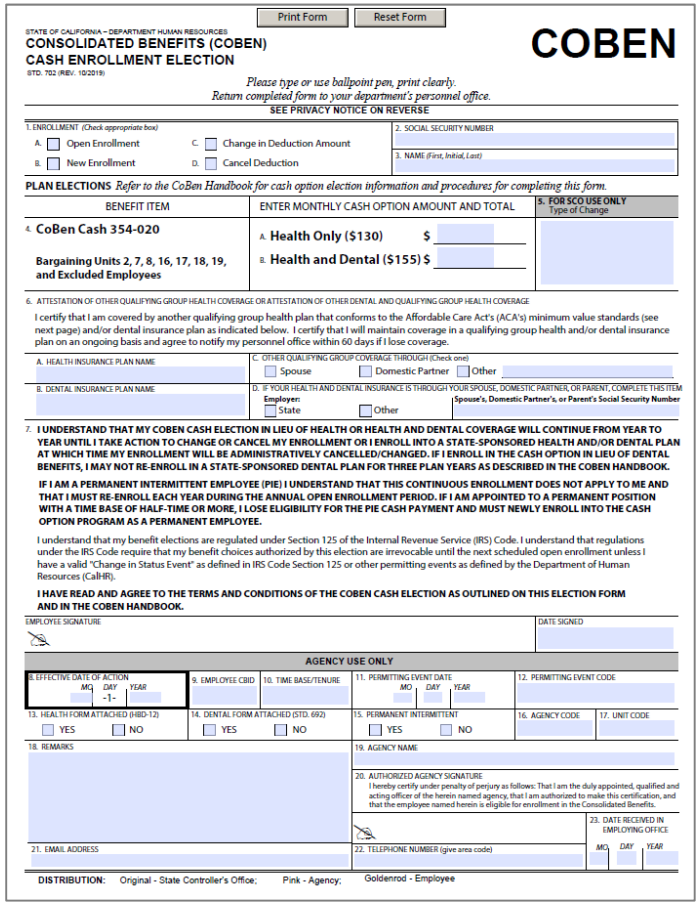
A. HEALTH INSURANCE CARRIER'S NAME
C. OTHER QUALIFYING GROUP HEALTH COVERAGE THROUGH (Check one) ☐ Spouse ☐ Domestic Partner ☐ Other
B. DENTAL INSURANCE CARRIER'S NAME
D. IF YOUR HEALTH AND/OR DENTAL INSURANCE IS THROUGH YOUR SPOUSE, DOMESTIC PARTNER, OR PARENT, COMPLETE THIS ITEM Employer: ☐ State ☐ Other — Spouse's, Domestic Partner's, or Parent's Social Security Number

7. **I UNDERSTAND THAT MY FLEXELECT CASH OPTION ENROLLMENT IN LIEU OF HEALTH AND/OR DENTAL COVERAGE WILL CONTINUE FROM YEAR TO YEAR UNTIL I TAKE ACTION TO CHANGE OR CANCEL MY ENROLLMENT OR I ENROLL INTO A STATE-SPONSORED HEALTH AND/OR DENTAL PLAN AT WHICH TIME MY ENROLLMENT WILL BE ADMINISTRATIVELY CANCELLED/CHANGED. IF I ENROLL IN THE CASH OPTION IN LIEU OF DENTAL BENEFITS, I MAY NOT RE-ENROLL IN A STATE-SPONSORED DENTAL PLAN FOR THREE PLAN YEARS AS DESCRIBED IN THE FLEXELECT HANDBOOK.**
IF I AM A PERMANENT INTERMITTENT EMPLOYEE (PIE) I UNDERSTAND THAT THIS CONTINUOUS ENROLLMENT DOES NOT APPLY TO ME AND THAT I MUST RE-ENROLL EACH YEAR DURING THE ANNUAL OPEN ENROLLMENT PERIOD. IF I AM APPOINTED TO A PERMANENT POSITION WITH A TIME BASE OF HALF-TIME OR MORE, I LOSE ELIGIBILITY FOR THE PIE CASH PAYMENT AND MUST NEWLY ENROLL INTO THE CASH OPTION PROGRAM AS A PERMANENT EMPLOYEE.
I have reviewed the handbook describing the State of California's optional FlexElect Program, including the legal definitions and change in benefit election limitations authorized under Section 125 of the Internal Revenue Service (IRS) Code. I understand that regulations under the IRS Code require that my benefit choices authorized by this election form are irrevocable during my entire period of enrollment unless I have a valid "Change in Status Event" as defined in these regulations or other permitting events as described in the FlexElect Handbook. I also agree to pay the administrative fee through payroll deduction on a post-tax basis.
I HAVE READ AND AGREE TO THE TERMS AND CONDITIONS OF THE FLEXELECT PROGRAM AS OUTLINED ON THIS ENROLLMENT FORM AND IN THE FLEXELECT HANDBOOK.

EMPLOYEE SIGNATURE — DATE SIGNED

AGENCY USE ONLY

8. EFFECTIVE DATE OF ACTION MO DAY YEAR -1-
9. EMPLOYEE CBID
10. TIME BASE/TENURE
11. PERMITTING EVENT DATE MO DAY YEAR
12. PERMITTING EVENT CODE
13. HEALTH FORM ATTACHED (HBD-12) ☐ YES ☐ NO
14. DENTAL FORM ATTACHED (STD. 692) ☐ YES ☐ NO
15. PERMANENT INTERMITTENT ☐ YES ☐ NO
16. AGENCY CODE
17. UNIT CODE
18. REMARKS
19. AGENCY NAME
20. AUTHORIZED AGENCY SIGNATURE
I hereby certify under penalty of perjury as follows: That I am the duly appointed, qualified and acting officer of the herein named agency, that I am authorized to make this certification, and that the employee named herein is eligible for enrollment in the State FlexElect Program.
21. EMAIL ADDRESS
22. TELEPHONE NUMBER (give area code)
23. DATE RECEIVED IN EMPLOYING OFFICE MO DAY YEAR



Print Form Reset Form

STATE OF CALIFORNIA – DEPARTMENT OF HUMAN RESOURCES
CONSOLIDATED BENEFITS (COBEN) CASH ENROLLMENT ELECTION
STD. 702 (REV. 10/2019)

COBEN

Please type or use ballpoint pen, print clearly.
Return completed form to your department's personnel office.
SEE PRIVACY NOTICE ON REVERSE

1. ENROLLMENT *(Check appropriate box)*
A. ☐ Open Enrollment C. ☐ Change in Deduction Amount
B. ☐ New Enrollment D. ☐ Cancel Deduction

2. SOCIAL SECURITY NUMBER
3. NAME *(First, Initial, Last)*

PLAN ELECTIONS *Refer to the CoBen Handbook for cash option election information and procedures for completing this form.*

BENEFIT ITEM	ENTER MONTHLY CASH OPTION AMOUNT AND TOTAL	5. FOR SCO USE ONLY Type of Change
4. CoBen Cash 354-020 Bargaining Units 2, 7, 8, 16, 17, 18, 19, and Excluded Employees	A. Health Only ($130) $ B. Health and Dental ($155) $	

6. ATTESTATION OF OTHER QUALIFYING GROUP HEALTH COVERAGE OR ATTESTATION OF OTHER DENTAL AND QUALIFYING GROUP HEALTH COVERAGE
I certify that I am covered by another qualifying group health plan that conforms to the Affordable Care Act's (ACA's) minimum value standards (see next page) and/or dental insurance plan as indicated below. I certify that I will maintain coverage in a qualifying group health and/or dental insurance plan on an ongoing basis and agree to notify my personnel office within 60 days if I lose coverage.

A. HEALTH INSURANCE PLAN NAME
C. OTHER QUALIFYING GROUP COVERAGE THROUGH (Check one) ☐ Spouse ☐ Domestic Partner ☐ Other
B. DENTAL INSURANCE PLAN NAME
D. IF YOUR HEALTH AND DENTAL INSURANCE IS THROUGH YOUR SPOUSE, DOMESTIC PARTNER, OR PARENT, COMPLETE THIS ITEM Employer: ☐ State ☐ Other — Spouse's, Domestic Partner's, or Parent's Social Security Number

7. **I UNDERSTAND THAT MY COBEN CASH ELECTION IN LIEU OF HEALTH OR HEALTH AND DENTAL COVERAGE WILL CONTINUE FROM YEAR TO YEAR UNTIL I TAKE ACTION TO CHANGE OR CANCEL MY ENROLLMENT OR I ENROLL INTO A STATE-SPONSORED HEALTH AND/OR DENTAL PLAN AT WHICH TIME MY ENROLLMENT WILL BE ADMINISTRATIVELY CANCELLED/CHANGED. IF I ENROLL IN THE CASH OPTION IN LIEU OF DENTAL BENEFITS, I MAY NOT RE-ENROLL IN A STATE-SPONSORED DENTAL PLAN FOR THREE PLAN YEARS AS DESCRIBED IN THE COBEN HANDBOOK.**
IF I AM A PERMANENT INTERMITTENT EMPLOYEE (PIE) I UNDERSTAND THAT THIS CONTINUOUS ENROLLMENT DOES NOT APPLY TO ME AND THAT I MUST RE-ENROLL EACH YEAR DURING THE ANNUAL OPEN ENROLLMENT PERIOD. IF I AM APPOINTED TO A PERMANENT POSITION WITH A TIME BASE OF HALF-TIME OR MORE, I LOSE ELIGIBILITY FOR THE PIE CASH PAYMENT AND MUST NEWLY ENROLL INTO THE CASH OPTION PROGRAM AS A PERMANENT EMPLOYEE.
I understand that my benefit elections are regulated under Section 125 of the Internal Revenue Service (IRS) Code. I understand that regulations under the IRS Code require that my benefit choices authorized by this election are irrevocable until the next scheduled open enrollment unless I have a valid "Change in Status Event" as defined in IRS Code Section 125 or other permitting events as defined by the Department of Human Resources (CalHR).
I HAVE READ AND AGREE TO THE TERMS AND CONDITIONS OF THE COBEN CASH ELECTION AS OUTLINED ON THIS ELECTION FORM AND IN THE COBEN HANDBOOK.

EMPLOYEE SIGNATURE — DATE SIGNED

AGENCY USE ONLY

8. EFFECTIVE DATE OF ACTION MO DAY YEAR -1-
9. EMPLOYEE CBID
10. TIME BASE/TENURE
11. PERMITTING EVENT DATE MO DAY YEAR
12. PERMITTING EVENT CODE
13. HEALTH FORM ATTACHED (HBD-12) ☐ YES ☐ NO
14. DENTAL FORM ATTACHED (STD. 692) ☐ YES ☐ NO
15. PERMANENT INTERMITTENT ☐ YES ☐ NO
16. AGENCY CODE
17. UNIT CODE
18. REMARKS
19. AGENCY NAME
20. AUTHORIZED AGENCY SIGNATURE
I hereby certify under penalty of perjury as follows: That I am the duly appointed, qualified and acting officer of the herein named agency, that I am authorized to make this certification, and that the employee named herein is eligible for enrollment in the Consolidated Benefits.
21. EMAIL ADDRESS
22. TELEPHONE NUMBER (give area code)
23. DATE RECEIVED IN EMPLOYING OFFICE MO DAY YEAR

DISTRIBUTION: Original - State Controller's Office; Pink - Agency; Goldenrod - Employee

CALHR
CALIFORNIA DEPARTMENT OF HUMAN RESOURCES

Effective Dates

- Standard Events
  - First of the following month when a correctly completed enrollment form is received at SCO by the 10th AND does not have to be returned to the agency for correction
- Mandatory Events
  - First of the month following the event

Dental: Three Year Commitment

- Must remain enrolled in Cash Option for three plan years
  - Disclosed on the STD 701C and 702
  - Personnel offices must confirm eligibility before an employee enrolls in dental coverage
- Exceptions
  - Lose their other dental coverage (60 day window)
  - Cancel both their health and dental CoBen Cash Option during open enrollment

PI Employees

- Eligibility Requirements
  - Have been eligible for health and/or dental for the entire January through June control period
  - Be paid for at least 480 hours worked during the January through June control period
  - Have a PI appointment from January 1 through June 30 of the plan year for which they enrolled
  - Have completed a STD 701C or 702 during open enrollment or as a newly eligible employee

PI Employees, 2

- Enrollment Requirements
  - Employee must complete a form STD 701C (FlexElect) or 702 (CoBen) during open enrollment
    - Must re-enroll each year
  - Personnel offices retain the form until July of the following year

PI Employees, 3

- If employee meets the eligibility definition, personnel offices submit to SCO for processing along with a STD 674
  - Add in the remarks of the 674 "I certify this PI employee has worked 480 hours during the January – June _____ (YEAR) control period and meets all other eligibility criteria for the Cash Option payment of _____ (AMOUNT DUE)"
  - SCO must receive the forms by September 1

PI Cash Option Lump Sum Amounts

Coverage	FlexElect	CoBen
Health Only	$768	$780
Dental Only	$72	Not available
Health and Dental	$840	$930
Administrative Fee	$12	$0

- Unit 6 employees may not receive the FlexElect Cash Option in lieu of their dental insurance

Change in Status Events

Permitting Events

- Marriage, divorce, legal separation, or annulment
- Birth or adoption of a child
- Death of a spouse or dependent
- Loss or commencement of spouse's coverage due to an employment status change
- Change in employee's or spouse's work schedule that results in a loss or gain of eligibility and coverage

Loss of Eligibility

- Change to a time base that is less than half-time
- Change to an appointment that is not permanent (such as LT or TAU) unless otherwise defined under Eligibility Criteria
- Change to a Permanent-Intermittent (PI) position (may possibly reenroll as a newly eligible PI)

Loss of Eligibility Procedures

- A 701C (FlexElect) or 702 (CoBen) must be processed to cancel the Cash Option
  - Employees may complete the form and submit to the personnel office; or
  - Personnel offices may complete as an administrative cancellation but must notify employee

Appeals Process

- CalHR will review appeals submitted by personnel offices on a case by case basis in the event of an administrative error

Email
flexelect@calhr.ca.gov
CoBen@calhr.ca.gov

Fax
(855) 629-7814

Differentiators

- LT and TAU appointments
- Bargaining unit eligibility
- Cash Option amounts

FlexElect Reimbursement Accounts

Learning Objectives

- Know what the types of accounts are
- Understand eligibility
- Qualified expenses
- Claims filing process
- COBRA application

FlexElect Programs

Medical Reimbursement Account (MRA)

Health, dental and vision expenses

No Federal, State, or Social Security taxes withheld

Dependent Care Reimbursement (DCRA)

Dependent care expenses while working or looking for work

No Federal, State, or Social Security taxes withheld

Cash Option

Eligibility Criteria

State employees designated:	Additional Requirements:
• Rank and File • Managerial • Supervisory • Confidential • All other employees excluded from collective bargaining	• Permanent status • Limited-term or TAU • Mandatory right of return to a permanent position • Work one-half time or more

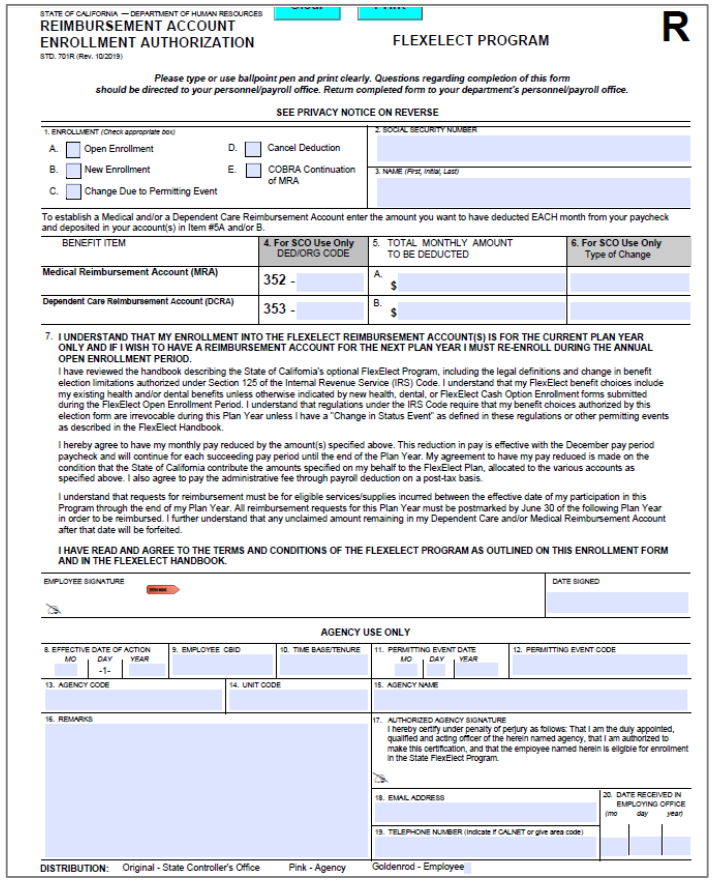
Reimbursement Accounts

Available Accounts	
Medical Reimbursement Account (MRA) Max Election: $2,750 per year Minimum Election: $10 per month	Dependent Care Reimbursement Account (DCRA) Max Election: $5,000 per year per household; $2,500 if married and filing separately

Enrollment Form Submission

- Employees must complete a STD 701R to enroll
  - Must re-enroll each open enrollment period
- Confirm monthly deduction amounts do not exceed the plan maximums
  - MRA: $229.16
  - DCRA: $416.66
  - Newly Enrolled Exception: May elect more than the monthly maximum based on the remaining paychecks for the year

Reimbursement Account Enrollment Authorization



STATE OF CALIFORNIA — DEPARTMENT OF HUMAN RESOURCES

REIMBURSEMENT ACCOUNT ENROLLMENT AUTHORIZATION

STD. 701R (Rev. 10/2019)

FLEXELECT PROGRAM

R

Please type or use ballpoint pen and print clearly. Questions regarding completion of this form should be directed to your personnel/payroll office. Return completed form to your department's personnel/payroll office.

SEE PRIVACY NOTICE ON REVERSE

1. ENROLLMENT (Check appropriate box)

A. ☐ Open Enrollment
B. ☐ New Enrollment
C. ☐ Change Due to Permitting Event
D. ☐ Cancel Deduction
E. ☐ COBRA Continuation of MRA

2. SOCIAL SECURITY NUMBER

3. NAME (First, Initial, Last)

To establish a Medical and/or a Dependent Care Reimbursement Account enter the amount you want to have deducted EACH month from your paycheck and deposited in your account(s) in Item #5A and/or B.

BENEFIT ITEM	4. For SCO Use Only DED/ORG CODE	5. TOTAL MONTHLY AMOUNT TO BE DEDUCTED	6. For SCO Use Only Type of Change
Medical Reimbursement Account (MRA)	352 -	A. $	
Dependent Care Reimbursement Account (DCRA)	353 -	B. $	

7. **I UNDERSTAND THAT MY ENROLLMENT INTO THE FLEXELECT REIMBURSEMENT ACCOUNT(S) IS FOR THE CURRENT PLAN YEAR ONLY AND IF I WISH TO HAVE A REIMBURSEMENT ACCOUNT FOR THE NEXT PLAN YEAR I MUST RE-ENROLL DURING THE ANNUAL OPEN ENROLLMENT PERIOD.**

I have reviewed the handbook describing the State of California's optional FlexElect Program, including the legal definitions and change in benefit election limitations authorized under Section 125 of the Internal Revenue Service (IRS) Code. I understand that my FlexElect benefit choices include my existing health and/or dental benefits unless otherwise indicated by new health, dental, or FlexElect Cash Option Enrollment forms submitted during the FlexElect Open Enrollment Period. I understand that regulations under the IRS Code require that my benefit choices authorized by this election form are irrevocable during this Plan Year unless I have a "Change in Status Event" as defined in these regulations or other permitting events as described in the FlexElect Handbook.

I hereby agree to have my monthly pay reduced by the amount(s) specified above. This reduction in pay is effective with the December pay period paycheck and will continue for each succeeding pay period until the end of the Plan Year. My agreement to have my pay reduced is made on the condition that the State of California contribute the amounts specified on my behalf to the FlexElect Plan, allocated to the various accounts as specified above. I also agree to pay the administrative fee through payroll deduction on a post-tax basis.

I understand that requests for reimbursement must be for eligible services/supplies incurred between the effective date of my participation in this Program through the end of my Plan Year. All reimbursement requests for this Plan Year must be postmarked by June 30 of the following Plan Year in order to be reimbursed. I further understand that any unclaimed amount remaining in my Dependent Care and/or Medical Reimbursement Account after that date will be forfeited.

I HAVE READ AND AGREE TO THE TERMS AND CONDITIONS OF THE FLEXELECT PROGRAM AS OUTLINED ON THIS ENROLLMENT FORM AND IN THE FLEXELECT HANDBOOK.

EMPLOYEE SIGNATURE

DATE SIGNED

AGENCY USE ONLY

8. EFFECTIVE DATE OF ACTION (MO DAY YEAR) -1-
9. EMPLOYEE CSID
10. TIME BASE/TENURE
11. PERMITTING EVENT DATE (MO DAY YEAR)
12. PERMITTING EVENT CODE
13. AGENCY CODE
14. UNIT CODE
15. AGENCY NAME
16. REMARKS
17. AUTHORIZED AGENCY SIGNATURE
I hereby certify under penalty of perjury as follows: That I am the duly appointed, qualified and acting officer of the herein named agency, that I am authorized to make this certification, and that the employee named herein is eligible for enrollment in the State FlexElect Program.
18. EMAIL ADDRESS
19. TELEPHONE NUMBER (Indicate if CALNET or give area code)
20. DATE RECEIVED IN EMPLOYING OFFICE (mo day year)

DISTRIBUTION: Original - State Controller's Office Pink - Agency Goldenrod - Employee

CALHR
CALIFORNIA DEPARTMENT OF HUMAN RESOURCES

Effective Dates

- Standard Events
  - First of the following month when a correctly completed enrollment form is received at SCO by the 10th AND does not have to be returned to the agency for correction
- Mandatory Events
  - First of the month following the event

How to Get Reimbursed

- Complete CalHR 351 (FlexElect Reimbursement Claim Form, Rev. 7/2016) after expense is incurred
- Submit form and supporting documentation to ASIFlex via mail, fax, through their online portal or their mobile app
- ASI will process the claim and SCO will generate checks
  - Note: Direct deposit may also be set up through ASI's portal

Replacement Checks – Lost or Stolen

- Process
  - Employee must submit the following information:
    - Warrant number
    - Issue date
    - Warrant amount
    - Address
  - Employees may contact ASI if they do not have this information

Replacement Checks – Lost or Stolen, 2

- Once obtained, employee can email check information to FlexElectStopPaymentRequest@calhr.ca.gov
  - CalHR completes a portion of the form and emails to the employee
- Employee mails completed form to SCO for processing
  - Turnaround for processing is approximately 14 days

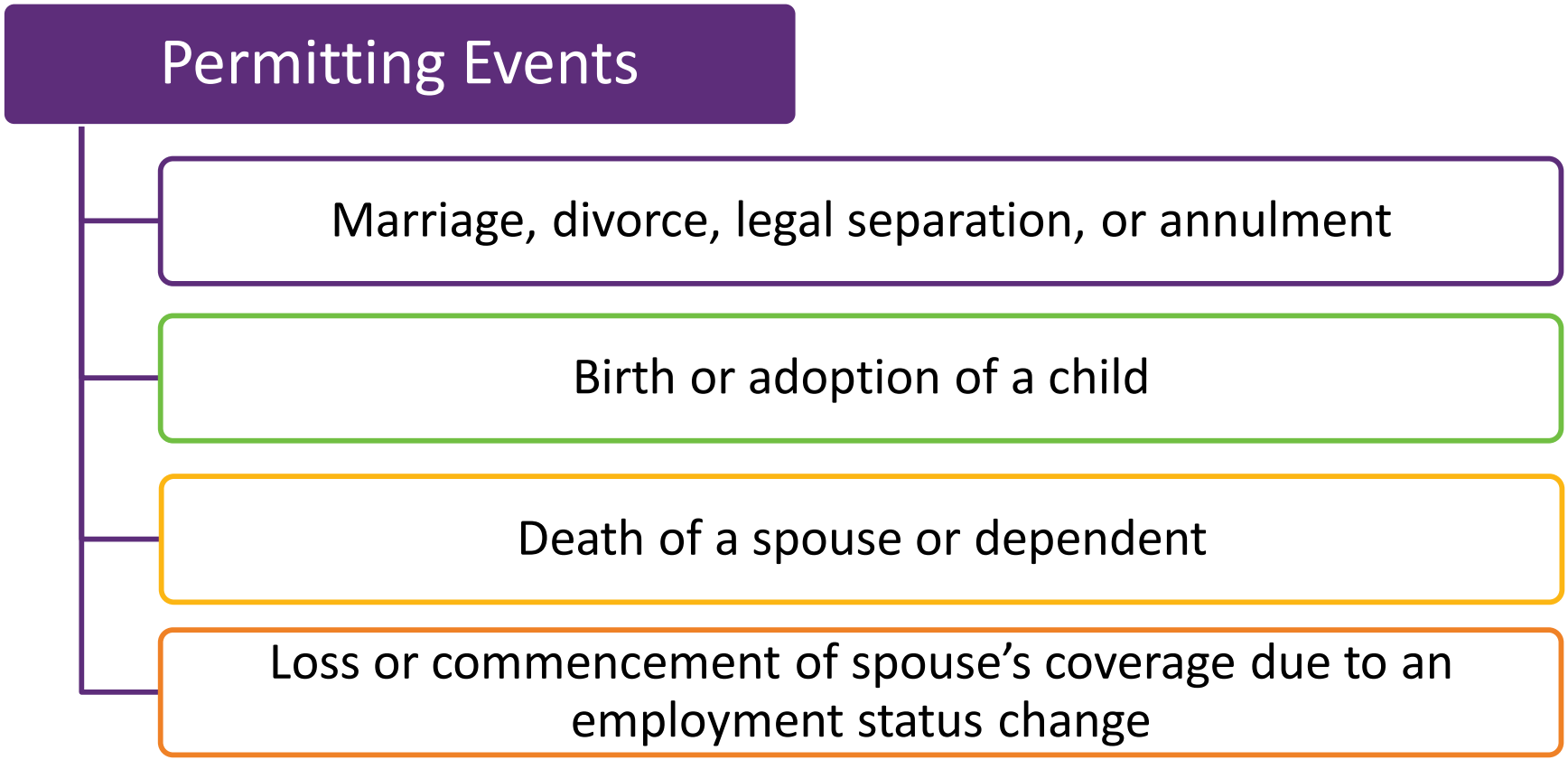
Replacement Checks – Stale

- Employees can now send their requests to FlexElectStopPaymentRequest@calhr.ca.gov
  - Must submit a copy of their check or provide complete check information

Claims Deadlines

Plan Year	• January 1 – December 31
Grace Period	• March 15 of the following plan year
Claims Filing Deadline	• June 30 of the following plan year

Change in Status Events



Loss of Eligibility

- Change to a time base that is less than half-time
- Change to an appointment that is not permanent (such as LT or TAU) unless the employee has a mandatory right of return to a permanent position with a time base that is half-time or more
- Change to a Permanent-Intermittent (PI) position
  - Reminder: PIs are not eligible for the reimbursement accounts

Loss of Eligibility Procedure

- A 701R must be completed to cancel an employee's enrollment
  - Employee may complete the 701R and submit to the personnel office for processing
  - Cancellation may be processed administratively by personnel offices
    - The personnel office is responsible for notifying the employee when an administrative FlexElect cancellation is done

MRAs and COBRA

- MRAs are eligible plans to be continued for the duration of the plan year under COBRA
  - DCRAs are not considered a benefit eligible for COBRA
- Eligibility
  - Employee loses eligibility to continue to incur claims as of the date they lose active pay status
  - Employee may continue their monthly contributions up to the end of the current plan year to maintain eligibility
  - If not, any remaining funds are forfeited

Appeals Process

- CalHR will review appeals submitted by personnel offices on a case by case basis in the event of an administrative error

Email
flexelect@calhr.ca.gov

Fax
(855) 629-7814